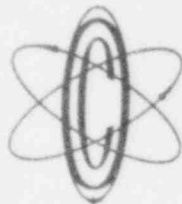


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OYSTER CREEK



NUCLEAR GENERATING STATION



Jersey Central Power & Light Company is a Member of the General Public Utilities System

(609) 693-6000 P.O. BOX 388 • FORKED RIVER • NEW JERSEY • 08731

August 21, 1981

Mr. Boyce H. Grier, Director  
Office of Inspection and Enforcement  
Region I  
United States Nuclear Regulatory Commission  
631 Park Avenue  
King of Prussia, Pennsylvania 19406



Dear Mr. Grier:

SUBJECT: Oyster Creek Nuclear Generating Station  
Docket No. 50-219  
Licensee Event Report  
Reportable Occurrence No. 50-219/81-34/3L

This letter forwards three copies of a Licensee Event Report to report Reportable Occurrence No. 50-219/81-34/3L in compliance with paragraph 6.9.2.b.3 of the Technical Specifications.

Very truly yours,

*J. T. Carroll, Jr.*  
J. T. Carroll, Jr.  
Acting Director Oyster Creek

JTC:dh  
Enclosures

cc: Director (40 copies)  
Office of Inspection and Enforcement  
United States Nuclear Regulatory Commission  
Washington, D.C. 20555

Director (3)  
Office of Management Information  
and Program Control  
United States Nuclear Regulatory Commission  
Washington, D. C. 20555

NRC Resident Inspector (1)  
Oyster Creek Nuclear Generating Station  
Forked River, N. J.

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OYSTER CREEK NUCLEAR GENERATING STATION  
Forked River, New Jersey 08731

Licensee Event Report  
Reportable Occurrence No. 50-219/81-34/3L

Report Date

August 21, 1981

Occurrence Date

July 22, 1981

Identification of Occurrence

Violation of Technical Specifications in that an inadequacy in the implementation of administrative controls led to operation in a mode which could lead to a reduction of the margin of safety provided in the fuel cladding integrity safety limit when the peaking factor was at 110% of its allowable limit.

This event is considered to be a reportable occurrence as defined in the Technical Specifications, paragraph 6.9.2.b.3.

Conditions Prior to Occurrence

The plant was in steady state operation at 62 percent power.

Plant Parameters at the time of the occurrence are:

Power:	Core	1071 MWt
	Electrical	280 MWe
Flow:	Recirculation	$11.3 \times 10^4$ gpm
	Feedwater	$3.81 \times 10^6$ lb/hr

Description of Occurrence

On July 22, during a load reduction after failure of Traveling Screens 1 and 2 and the removal of Circulating Pump 1-1 from service, the control rod configuration resulted in a peaking factor that was 110% of its allowable limit. When this result became available from the plant process computer, actions were already underway to return the control rod pattern to its steady state configuration.

Apparent Cause of Occurrence

The apparent causes of this occurrence are attributed to personnel error and procedural inadequacy in the review of control rod configuration instructions for off-hours load maneuvers. The wrong group of control rods was specified for insertion.

Analysis of Occurrence

Technical Specifications Section 2.1.A.2 specifies Safety Limits for combinations of core thermal power and recirculation flow for total peaking factor multiplier greater than unity. Under conditions occurring during the event, the Safety Limit for core thermal power at the specified recirculation flow was approximately 1610 MWt. The peak core thermal power during the event was approximately 1059 MWt. The safety significance of this event is considered to be minimal since none of the limits on the thermal hydraulic variables assuring integrity of the fuel cladding were approached. In addition, those actions which subsequently increased core power, reduced the peaking factor to 66 percent of the allowable limit.

Corrective Action

A revision to Procedure 1001.22 has been initiated as a result of this occurrence which requires that prior to issue, written instructions for control rod maneuvers be independently reviewed. This should reduce the possibility that this situation will recur.

Failure Data

Not applicable.